

Please return item(s) **sterilized** and packed **separately!**

# Complaint Form

The fields marked with an \* are **required!**

*to be filled by selling location*

Selling Location/ DI Division: \_\_\_\_\_

Complaint ref. no. of Selling Location/ DI Division: \_\_\_\_\_ Complaint no: \_\_\_\_\_

### Use Practice Stamp

### Practice/Dentist

DentsplySirona accountnumber \_\_\_\_\_

**or** Name \_\_\_\_\_

Street \_\_\_\_\_

Adress \_\_\_\_\_

Contact/Phone \_\_\_\_\_

### Failed product \* (choose at least one! Implant, Component, Tool etc.)

Astra Tech Implant System    MIS    Ankylos    Frialit/ Xive    \_\_\_\_\_

Name \_\_\_\_\_ Catalog no. \_\_\_\_\_ Lot no. \_\_\_\_\_ unknown

Concomitant product: \_\_\_\_\_

### Event \* (choose at least one event!)

Date of Event\* \_\_\_\_ - \_\_\_\_ - \_\_\_\_

No Primary Stability    Implant Loss    Fracture of Implant

Other Surgical or Insertion Issue (please describe below)

Abutment Fracture    Screw Fracture    Loosening    Fit Issue

Tool Issue (please describe below)

Other (please describe below)

Additional Information/ Description

Position\* (mandatory to choose at least 1 position)

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R															L
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Patient Identifier\* \_\_\_\_\_

Oral Hygiene	excellent	fair	poor	
Bone Quality	I	II	III	IV
Medical History	Smoker	Diabetes	Bruxism	
Chewing/ Bite Habits	_____			
Others	_____			

Date of	Implant placement*	____ - ____ - ____	Immediate Impl. Placement	yes	no
	Loss/ explantation*	____ - ____ - ____	Immediate Loading	yes	no
	Prosthetic Restoration	____ - ____ - ____	Type of abutment	_____	

Time of Implant Loss/ Explantation	Healing Period	Re-entry	Prior to Functional Loading	After Functional Loading
	Subgingival	Transgingival		
Healing				
Augmentation	Preoperative	At Time of Implant Placement		None
	Grafting Materials _____			

Implant Site Preparation	Bone Condensing	Bone Expanding	Bone Spreading	
	Drilling	Thread Cutter	Others	_____

Diagnostic Findings before Explantation	Infection	Mobility	Osteolysis
	Occlusal Overload	Progressive Bone Loss	Periimplantitis

Prosthetic Treatment	Cemented	Complete Denture	Only Implant supported	Removable Bridge
	Fixed Bridge	Fixed Partial Denture	Removable Partial Denture	Screw Retained
	Implant/ Tooth supported		Single Tooth	

**Additional Comments**

Item enclosed other attachments \_\_\_\_\_

Item will be sent subsequently \_\_\_\_\_

Item won't be returned because \_\_\_\_\_

Date\* \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Signature\*